



Code of Compliance and Ethical Standards


Youth & Family Centered Services



O P E N I N G N E W D O O R S




This YFCS Code of Corporate Compliance and Ethical Standards was approved and made effective May 1, 2000.



Kevin P. Sheehan
Chairman, CEO and President of
Youth & Family Centered Services, Inc.,
and as President of its subsidiaries

Periodic Reviews

Review Date: <u>4/27/10</u>	Revision? (Y/N) <u>Y</u>	By: 
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Dear YFCS Associate,

Youth and Family Centered Services' commitment is to "Open New Doors for Abused and Neglected Children and Adolescents." This commitment was chosen to reflect not only our commitment to the children and adolescents we serve, but also the manner in which we conduct our business, in an "Open Door" manner and in accordance with applicable laws and ethical standards. For an individual or a corporation, there is no greater asset than a sterling reputation. We must never tarnish our reputations by becoming involved in business practices that are illegal or unethical.

In furtherance of this commitment to ethical business practices, YFCS has a long-standing Compliance Program. Our Code of Compliance and Ethical Standards gives every employee and associate of YFCS and its affiliated entities a clear understanding of what is expected from each of us with respect to the Compliance Program. It has been approved by the YFCS Compliance Committee, and it represents an affirmation of our commitment to high quality service and to compliance with applicable laws and ethical business practices. Every YFCS associate has an obligation to become familiar with this Code of Compliance and Ethical Standards and to abide by it.

YFCS is committed to maintaining an "Open Door" policy and to providing "open lines of communication" with respect to compliance. If you ever have a concern that a law or ethical standard is being violated or is about to be violated, please raise your concern. Remember, it is always better to raise a question before taking action that may be improper. It is YFCS policy that no one will be penalized for raising an issue or concern in good faith. You will find in this Code of Compliance and Ethical Standards a simple procedure for raising any concern you may have that a law or YFCS Compliance policy is being or is about to be violated.

I pledge the full commitment of YFCS to the principles set forth in this Code of Compliance and Ethical Standards and in the Compliance Program. YFCS' reputation and continued success depend upon each associate's commitment to delivering the appropriate level of care and to conducting business in accordance with applicable laws and ethical standards.

Sincerely,

Signature on File

Kevin Sheehan

Chairman of the Board, President and
Chief Executive Officer

Table of Contents

Expectations and Purposes.....	1
Fundamental Obligations	1
The YFCS Inquiry and Reporting Process	2
YFCS Confidential Ethics Line	3
Regulatory Compliance	3
Federal False Claims Act—What is a Violation?	3
What are the Penalties?	4
Who Can Make a Claim for a Violation?	4
Retaliation Prohibited	4
Administrative Remedies	4
State Rules and Regulations	5
YFCS Compliance	5
Relationships with Patients	5
Education and Training	6
Proper Documentation	6
Billing for Services	6
Marketing and Advertising	7
Financial Relationships with Physicians	7
Relationships with Vendors and Contractors	8
Credentialing and Excluded Provider Policy	8
Dealing with Accrediting Bodies	9
Government Investigations	9
Internal Investigations	10
Corrective Action	10
Evaluation of Adherence	10
Consequences of Violations, Including Discipline	11

Revisions to YFCS Compliance Program 11

Acknowledgment Process 11

YFCS Code of Compliance and Ethical Standards Acknowledgment

YFCS Compliance Contact Information

Schedule of State Medicaid Fraud Laws

- Arizona
- Arkansas
- Florida
- Indiana
- Mississippi
- Missouri
- New Mexico
- Pennsylvania
- Texas

Expectations and Purposes

Youth & Family Centered Services, Inc. ("YFCS") expects and requires all entities affiliated with it and their employees, contractors, volunteers, vendors, and suppliers ("YFCS associates") to follow the federal, state, and local laws, including all federal health care program requirements; the requirements of that Settlement Agreement and Mutual Releases dated April 22, 2009 between YFCS, Southwood Psychiatric Hospital, and the federal government ("Settlement Agreement"), including YFCS' policies and procedures implemented pursuant to the Settlement Agreement; and all other compliance-related policies comprising the YFCS Compliance Program, which closely follows the recommendations of the U.S. Department of Health and Human Services' Office of Inspector General ("OIG") for the design of an effective Compliance Program. YFCS intends for its Compliance Program to assist in preventing illegal conduct from occurring in YFCS facilities/programs ("facilities") and within its employee health plans and to demonstrate YFCS' commitment to compliance with applicable laws. All YFCS associates have an obligation to adhere to the tenets of the Compliance Program. In addition, YFCS expects those who perform management services at YFCS facilities and who administer its employee health plan to endorse and promote the Compliance Program. The Compliance Program is designed to:

- Maintain a Director of Compliance who is responsible for leading the Compliance effort, and who is assisted by a Deputy Director of Compliance, Regional Compliance Directors, and Local Compliance Officials;
- Advise YFCS associates of applicable laws and to provide guidance in complying with those laws;
- Ensure that the Compliance Program is taken seriously by all YFCS associates;
- Utilize a system of monitoring and oversight of business activity to ensure adherence to applicable laws; and
- Provide a means for reporting suspected unethical conduct and a mechanism for investigating such reports.

Fundamental Obligations

Certain obligations are fundamental to YFCS operations.

Obey the Law

Every YFCS associate is expected to be familiar with the basic legal requirements relevant to his or her duties.

Behave Ethically and Tell the Truth

Every YFCS associate is expected to conduct business with honesty and integrity,

and all communications within YFCS and to outside agencies must be truthful. Every YFCS associate must avoid using his or her position illegally or unethically for personal gain and must avoid conflicts of interest.

Report Possible Violations

Every associate is expected to utilize the YFCS Compliance Inquiry and Reporting Process (see details below) to ask about or report any activity he or she reasonably believes is a suspected violation of the law, including federal health care program requirements, or any of YFCS' policies and procedures. One need not be certain that a violation has occurred or will occur in order to ask about it or to report it. Inquiring and reporting enables YFCS to investigate potential problems quickly and to take prompt action to resolve them. Inquiries and reports may be made without fear of retribution or retaliation.

The YFCS Inquiry and Reporting Process

YFCS and its affiliates provide a variety of services in numerous states, and there are complex, ever-changing rules and regulations that govern the provision of and the reimbursement for each type of service. YFCS recognizes that this can create areas of uncertainty for employees who carry out daily operations. Questions and concerns about the correct way to handle different situations may, and often do, arise. Employees should use the following process to find the answers they need.

- **If you're in doubt about an issue or you have a concern, ask!**

Keep asking until you get an answer that makes sense. Is the action legal? Is it consistent with YFCS policies and procedures? If you know it is wrong, don't do it.

- **Follow the YFCS Inquiry and Reporting Process.**

Remember that it is always better to raise a question before taking an action that may be improper. It is YFCS policy to ensure that no associate is penalized for raising an issue or concern in good faith. Someone may be disciplined for reporting alleged misconduct if he or she knowingly and intentionally reports something that he or she knows to be false or misleading in order to harm another.

- Discuss the issue with your immediate supervisor. If you are not comfortable discussing the issue with your supervisor, go to the next step.
- Discuss the issue with a higher level manager where you work. If you are not comfortable taking this step, go to the next step.
- Discuss the issue with another resource, such as the Human Resources Director or Local Compliance Official where you work, your Regional Compliance

Director, or the YFCS Compliance Director (Call 512-327-1119 or email compliance@yfcs.com), or go to the next step.

- Call the YFCS Confidential Ethics Line at 1-800-500-0333 (Ethics Line explained below).

YFCS Confidential Ethics Line

Any individual may call the YFCS Confidential Ethics Line to ask questions concerning ethical or legal conduct or to report any potentially improper action.

Calls are not traced or recorded, and callers can report concerns confidentially, anonymously, and without fear of retribution or retaliation.

The YFCS Confidential Ethics Line provides an additional method of communicating when an employee is uncomfortable using other channels or needs additional assistance.

The Director of Compliance will initiate an investigation of issues that can not be otherwise resolved.

The Director of Compliance will monitor the matter through to resolution, and callers will be given a compliance number so they can call for an update at a later date.

Regulatory Compliance

YFCS affiliates provide varied services in many states. These services are provided only pursuant to Federal health care program requirements and appropriate federal, state, and local laws. Such regulations may include subjects such as fraud and abuse, conditions of participation, certificates of need, licenses, permits, accreditation, access to treatment, consent to treatment, medical record-keeping, access to medical records, confidentiality, patients' rights, medical staff membership and clinical privileges, corporate practice of medicine restrictions, and Medicaid rules. Employees, including management, and any contractors or agents of affiliated facilities are required to be aware of and adhere to all applicable laws, including Federal health care program requirements, and company policies.

Federal False Claims Act — What is a Violation?

One way in which the federal government encourages compliance with healthcare laws is through the Federal False Claims Act. The Federal False Claims Act makes it a crime for any person or organization to knowingly make a false record or file a false claim with the government for payment. Examples of possible false claims include knowingly billing for services that were not provided, falsifying records, double billing for

items or services, submitting bills for services never performed or items never furnished, making a claim for services or products at an inflated price, billing for services that were not ordered by a physician, failing to report overpayments or credit balances, billing for services that were provided at a substandard quality where the government would not pay, or failure to report fraud.

What are the Penalties?

Under the federal False Claims Act, any provider that knowingly submits a false or fraudulent claim for payment of Government funds is liable for fines which include a penalty of up to three times the Government's damages, civil penalties ranging from \$5,500 to \$11,000 per false claim, and the costs of the civil action against the entity that submitted the false claims. Further, if a provider is convicted of a False Claims Act violation, the Office of Inspector General may seek to exclude the provider or supplier from participation in federal health care programs.

Who Can Make a Claim for a Violation?

A person who knows of a false claim or fraudulent act can file a lawsuit in federal court on behalf of the government under a "*qui tam*" provision, commonly referred to as the "whistleblower" provision. The purpose of this *qui tam* suit is to recover the funds paid by the government as a result of the false claims. Sometimes the U.S. Government decides to join the *qui tam* suit. If the suit is ultimately successful, the person who initially brought the suit may be awarded a percentage of the funds recovered. The court may reduce the reporting person's share of the proceeds if the court finds that the reporting person planned and initiated the false claims violation. Further, if the reporting person is convicted of criminal conduct related to his/her role in the preparation or submission of the false claim(s), the reporting person will be dismissed from the civil action without receiving any portion of the proceeds.

Retaliation Prohibited

The Federal False Claims Act further protects anyone who files a *qui tam* lawsuit from being fired, demoted, threatened or harassed by their employer in retaliation for filing the suit. If a court finds that the employer retaliated against the employee, the court can order the employer to reinstate the employee, pay the employee back pay, and any other compensation arising from retaliatory conduct.

Administrative Remedies

Similarly, federal law known as the Program Fraud Civil Remedies Act of 1986 (the "PFCRA") provides administrative remedies for knowingly submitting false claims and statements. The PFCRA makes it illegal to submit a claim or statement asserting or omitting a material fact, or requesting payment for services not provided as claimed. A violation of the PFCRA results in a maximum civil penalty of \$5,000 per claim. In the event the Government has made any payment on the claim, in lieu of damages sustained by the Government, the person committing the violation also may be subject to an assessment of up to twice the amount of such claim.

State Rules and Regulations

Many states also have state laws for false claims and statements. Schedules of the applicable state laws are attached hereto and incorporated herein by reference.

YFCS Compliance

YFCS is committed to preparing and submitting accurate claims consistent with all Federal health care program requirements. Our YFCS Compliance program supports compliance with the fraud and abuse laws by:

- Monitoring and auditing to prevent or detect errors in coding and billing.
- Educating employees, including management and contractors, that they are responsible to report any concern about a possible false claim, and providing them with the reporting procedures.
- Investigating all reported concerns and correcting any billing errors discovered.
- Protecting our employees from adverse action when they do the right thing and report any genuine concern through the Confidential Ethics Line or to a member of management. YFCS will investigate any allegation of retaliation against an employee for speaking up.

YFCS encourages its employees, management, and contractors to report concerns to their immediate supervisor. If the supervisor is not deemed to be the appropriate contact or if the supervisor fails to respond quickly and appropriately to the concern, then the individual with the concern should be encouraged to discuss the situation with the facility's human resources manager, the facility's CEO or another member of management; or by calling the YFCS Confidential Ethics Line at (800) 500-0333; or by contacting the Compliance Director at (512) 327-1119 or compliance@yfcs.com.

Relationships with Patients

Quality of care is a key component of the YFCS Compliance Program. This commitment requires each YFCS associate who is involved with direct care to abide by the following principles:

- Employees will not knowingly bring harm to any patient/resident/client/Individual (collectively, "patients") and will protect patients from abuse or neglect at all times, which includes maintaining respect for the rights, dignity and integrity of each patient, following facility standards of care as outlined by licensing and accreditation requirements, and reporting any suspected or observed patient neglect and/or abuse per applicable facility and state reporting requirements and, if necessary, also via the YFCS Inquiry and Reporting Process.
- Employees will not become involved in relationships with patients, former patients, or patients' family members whereby the relationship is used for

personal gain or emotional need fulfillment at the expense of the patient's welfare.

- Employees will not become emotionally or physically involved with any patient in such a way as to transcend the bounds of the therapeutic relationship.
- Employees will not solicit or accept gratuities from patients or families, present or past, which exceed consideration as tokens of appreciation.

Education and Training

New YFCS employees and associates must receive compliance training during orientation. In addition, YFCS employees must attend periodic compliance training at least annually.

Proper Documentation

Each member of the YFCS team is responsible for the integrity and accuracy of the documents and records within their sphere of operation, not only to comply with Federal health care program requirements, but also to ensure that records will be available to support YFCS business practices and actions. No one may alter or falsify information on any record or document, and company books and records may not contain false or misleading information.

All professional services must be accurately and properly documented in a manner consistent with federal health care program requirements prior to billing for those services. Claims may only be submitted when appropriate documentation supports the claim and only when such documentation is maintained and is available for audit and review. In order to facilitate such audit and review, all records and medical notes should be appropriately organized in a legible form. Financial transactions should be recorded in accordance with generally accepted accounting principles and YFCS policies and standards.

Billing for Services

YFCS only bills for services actually rendered. Services rendered must be accurately and completely documented to ensure both proper billing and integrity of the medical data base. Billing must comply with the requirements of state and federal payors and conform to all payor contracts and agreements.

Substantiating medical documentation must be provided for all services rendered. Always bill on the principle that if the appropriate documentation has not been provided, the service has not been rendered. Medical records may be amended to correct an

error or complete documentation only in accordance with established medical records procedures -- and not for the purpose of covering up errors or obtaining any payment to which we are not entitled. Medical records may not be erased or altered. Billing data must be retained for periods described by law and by YFCS policies.

Clinical, administrative, or clerical staff involved in the preparation or submission of charge or billing data must be trained in proper claims and documentation practices. Any subcontractors engaged to perform billing services must have the necessary skills, quality assurance processes, and appropriate procedures to ensure that all billings for government and commercial insurance programs are accurate and complete.

When any payor agreement requires the collection of co-payments or deductible amounts, a good faith attempt must be made to collect these amounts to the full extent of the payor agreement. Co-payment or deductible waivers may be made only in accordance with the written policies of such payor and YFCS policy.

Employees who suspect that improper billing or documentation is occurring should immediately alert their supervisor or a higher level manager. The YFCS Compliance Director is also available for consultation. Additionally, any employee may call the YFCS Confidential Ethics Line if the issue remains of concern.

Marketing and Advertising

YFCS affiliated facilities may use marketing and advertising activities to educate the public, provide information to the community, increase awareness of YFCS services, and to recruit colleagues. Such marketing and advertising activities must present only truthful information.

Financial Relationships with Physicians

Any business arrangement with a physician or a physician's family member must be structured to ensure precise compliance with legal requirements. Such arrangements must be in writing and submitted for review in accordance with the YFCS Contract Approval policy, where the proposed arrangement will be analyzed in light of federal and state anti-kickback provisions and self-referral prohibitions. In order to ethically and legally meet all standards regarding referrals and admissions, we will adhere strictly to three rules:

1. **Do not pay for referrals.** YFCS facilities accept patient referrals and admissions based solely on the patient's clinical needs and our ability to render the needed services. We do not pay or offer to pay anyone -- colleagues, physicians, or other persons -- for referral of patients.

2. **Do not accept payments for referrals that we make.** No YFCS colleague or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another healthcare provider, we do not take into account the volume or value of referrals that the provider has made or may make to us.
3. **Adhere strictly to the terms of approved written business arrangements.** Violation of this policy may have grave consequences for the organization and the individuals involved, including civil and criminal penalties, and possible exclusion from participation in federally funded healthcare programs.

Relationships with Vendors and Contractors

YFCS and its affiliated entities must always employ the highest ethical standards of business practices in vendor and contractor selection, negotiation, determination of contract awards, and the administration of all purchasing activities. The selection of contractors, suppliers, and vendors must be made on the basis of objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service, and maintenance of adequate sources of supply. Purchasing decisions must be made on the contractor or supplier's ability to meet our needs, and not on personal relationships and friendships.

YFCS contractors that/who furnish Medicaid health care items or services or are involved in the monitoring of health care provided by a YFCS affiliate ("health care contractors") shall receive and adhere to the Code of Compliance and Ethical Standards, and comply with all other tenets of the YFCS Compliance Program. Such contractors include, but are not limited to, billers and coders, therapists, physicians, pharmacies, and medical supply vendors, but do not include copy or shredding services, grounds maintenance, and facility cafeteria contracted staff. Regardless of the type of contractor, however, YFCS contractors, suppliers and vendors should promptly report any compliance concerns to the Compliance Director (512-327-1119) or to the Confidential Ethics Line (1-800-500-0333).

Credentialing and Excluded Provider Policy

Prior to employing, contracting with, or in any way utilizing the services of a person who is required to be licensed, registered, or certified in order to perform the functions he or she will perform, the licensure, registration, or certification of such person must be verified.

Also, no YFCS facility may contract, by employment or otherwise, with an individual or entity which has been excluded from participation in a federally funded healthcare financing program, for the provision of items or services for which payment may be

made under such a program. Accordingly, prior to employing or contracting with any provider, appropriate steps must be taken to confirm that the provider has not been excluded.

Those steps include checking the individual or entity's name prior to retention and periodically thereafter (at least annually) against the Office of Inspector General's (OIG's) List of Excluded Individuals/Entities (LEIE), which may be found at <http://exclusions.oig.hhs.gov/>, the General Services Administration (GSA's) Excluded Parties List System (EPLS), which may be found at <http://epls.gov/>. If a YFCS facility learns that an individual or entity (either as an employer or contractor) is excluded, the YFCS facility must not hire or use that individual or entity.

Dealing with Accrediting Bodies

YFCS affiliated entities must deal with all accrediting bodies in a direct, open and honest manner. No action should ever be taken in relationships with accrediting bodies that would mislead the accreditor or its survey teams, either directly or indirectly.

The scope of matters related to accreditation of various bodies is extremely significant and broader than the scope of this Code of Compliance and Ethical Standards. The purpose of the Code of Compliance and Ethical Standards is to provide guidance on subjects of general application within the organization. In any case, all standards of an applicable accrediting group are important and must be followed.

Government Investigations

Government investigations are a fact of life in today's healthcare environment and procedures for cooperating with these investigations may be complex. If you become aware of a subpoena, search warrant, investigation or other legal action, immediately inform the administrator at your facility and call the YFCS Compliance Director (512-327-1119), notifying the person taking the call that you are calling concerning a potential government investigation. The Compliance Director will assist in verifying the credentials of the investigator, determining the legitimacy of the investigation, and following proper procedures for cooperating with the investigation.

YFCS associates must be forthright and courteous in dealing with any legitimate investigation. Requests for information must be answered with complete, factual, and accurate information. YFCS employees must never destroy or alter any company document in anticipation of a request for the document by a governmental entity. Also, YFCS employees must never lie or make false or misleading statements, or attempt to persuade any other person to provide false or misleading information, to any government investigator.

In some cases, government investigators, or persons presenting themselves as government investigators, may contact employees outside of the workplace, during non-work hours, or at home. Do not feel pressured to talk with the person under such circumstances without first contacting the administrator of your facility and the YFCS Compliance Director (512-327-1119). You may also consult your personal attorney. It is the legal right of YFCS employees to contact legal counsel before responding to questions by an investigator.

Internal Investigations

YFCS is committed to investigating all reported concerns promptly and confidentially to the fullest extent possible. The Director of Compliance will coordinate any findings from the investigations and immediately recommend corrective action or changes that need to be made. All members of the YFCS team are expected to cooperate with investigation efforts. Failure to cooperate can subject YFCS employees to disciplinary action, up to and including termination.

Corrective Action

Where an internal investigation substantiates a reported violation, it is YFCS policy to initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, instituting whatever disciplinary action is necessary, and implementing systemic changes to prevent a similar violation from recurring in the future at any YFCS facility.

Evaluation of Adherence

All employees and associates of YFCS and its affiliated entities will be evaluated periodically to determine their level of adherence to the YFCS Compliance Program. Such adherence is a condition of employment.

All managers at YFCS and its affiliated entities should:

1. adhere to and instruct their supervised employees and associates on the compliance policies and legal requirements applicable to their function,
2. inform all supervised personnel that strict compliance with these policies and requirements is a condition of employment, and
3. disclose to all supervised personnel that willfully or recklessly engaging in illegal activity or violating the YFCS Compliance Program may result in disciplinary action, including termination of employment.

Managers may be sanctioned for failure to instruct their subordinates adequately and

for failing to detect noncompliance with applicable policies and legal requirements, where reasonable diligence on the part of the manager or supervisor would have led to the discovery of such noncompliance and have given the organization the opportunity to correct them.

Consequences of Violations, Including Discipline

All violations of law, including failure to comply with federal and state health care program requirements, failure to comply with YFCS' policies and procedures, failure to comply with the Settlement Agreement, and failure to report any known violations will subject the associate(s) involved to disciplinary action. The precise discipline utilized will depend on the nature, severity, and frequency of the violation and may result in disciplinary actions up to and including termination.

Violations could also result in criminal, civil, or administrative fines, penalties or sanctions against YFCS, its affiliates, or its associates. Furthermore, violations could lead to exclusion of YFCS, its affiliates, or associates from participation in federal health care programs.

Revisions to YFCS Compliance Program

The YFCS Compliance Program is intended to be flexible and readily adaptable to changes in regulatory requirements and in the health care system as a whole. The Program will be regularly reviewed to assess whether it is working. The Program and this Code of Compliance and Ethical Standards will be altered if experience shows that a certain approach is not effective or a better alternative should be utilized. The YFCS Compliance Committee has the authority to amend the YFCS Compliance Program and this Code of Compliance and Ethical Standards as needed.

Acknowledgment Process

All YFCS employees and health care contractors are required to sign an acknowledgment confirming they have received the YFCS Code of Compliance and Ethical Standards and that they understand it represents fundamental and mandatory policies of YFCS and that they agree to fully comply with this Code. New employees and contractors will be required to sign the acknowledgment as a condition of employment and contractors will be required to sign the acknowledgment or sign a contract containing an acknowledgment of receipt of a hard copy. All YFCS workforce members and the public may also access an electronic copy via access to the YFCS internet webpage: www.yfcs.com.

YFCS Code of Compliance and Ethical Standards Acknowledgment

My signature on this form acknowledges that I have received and have read or agree to read the YFCS Code of Compliance and Ethical Standards.

I understand that the policies contained in the YFCS Code of Compliance and Ethical Standards represent fundamental and mandatory policies of YFCS, and I agree to comply fully with the standards contained in this Code. I understand that compliance with these standards, policies, and procedures is a condition of my continued employment or association with YFCS. I also understand that YFCS reserves the right to occasionally amend, modify, and update the Code of Compliance and Ethical Standards.

I also acknowledge that the Code of Compliance and Ethical Standards is only a statement of principles for individual and business conduct and does not, in any way, constitute an employment contract or an assurance of continued employment.

Signature Date: _____

Print Name

Name of YFCS Facility/Program you are associated with:

I am a (an) (Mark As Applicable):

Employee of a YFCS facility:

Contractor, Vendor, or other Supplier:

Name of Entity, if applicable: _____

YFCS Compliance Contact Information

YFCS Confidential Ethics Line - 1-800-500-0333

compliance@yfcs.com

YFCS Compliance Director: Vacant

Deputy Director of Compliance: Rick Neeck

Southwest Regional Compliance Director: Matt Frederiksen

Midwest Regional Compliance Director: Kathy Smalley

Southern Regional Compliance Director: Rick Neeck

Youth & Family Centered Services, Inc.
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Phone: 512-327-1119 or 800-835-KIDS

Fax: 512-327-4576

Schedule of State Medicaid Fraud Laws

- Arizona
- Arkansas
- Florida
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ARIZONA MEDICAID FRAUD LAWS

What is a Violation?

The State of Arizona has not yet passed a Medicaid false claims or fraud law. The rules and regulations under the federal False Claims Act apply.

What are the Penalties?

The State of Arizona has enacted the Arizona Health Care Cost Containment System which carries with it administrative rules, regulations and penalties for making false claims under its system. Claims made that a person knows or has reason to know are false are subject to a civil penalty not to exceed \$2,000 for each item or service claimed and an assessment not to exceed twice the amount claimed for each item or service.

Under the Arizona Criminal Code, individuals are subject to criminal penalties for acts such as receiving or accepting payment or other consideration for patient referrals or knowingly presenting false information or concealing facts which would result in an ineligible person qualifying for health coverage under the system. The criminal penalties range from a Class 1 misdemeanor to a Class 6 felony.

Who Can Make a Claim for a Violation?

Arizona does not have a provision allowing individuals to bring suit on behalf of the state. *See the federal False Claims Act.*

Retaliation Prohibited

Arizona has also established an Employment Protection Act similar to the federal False Claims Act's whistleblower protections. Specifically, employees may not be discharged for disclosing in a reasonable manner that the employee has information or a reasonable belief that the employer or an employee of the employer, has, is or will violate the statutes of the State of Arizona.

References: A.R.S. § 13-3713, A.R.S. § 23.1501, A.R.S. §§ 36.2903, *et seq.*

Rev'd 4/27/10

ARKANSAS MEDICAID FRAUD LAWS

What is a Violation?

Under the Arkansas Medicaid Fraud False Claims Act a person commits an unlawful act if, for example, a person knowingly: (i) makes any false statement or representation of a material fact in any application for a benefit or payment under the Arkansas Medicaid Program (the "Program"); (ii) purposely conceals or fails to disclose an event affecting a right to a benefit under the Arkansas Medicaid Program; (iii) converts a benefit or payment intended for another person to a use other than for the benefit of that person; (iv) solicits or receives a kickback, bribe or rebate in return for referrals; (v) offers to pay a kickback, bribe or rebate to induce a person to make a referral; or (vi) charges for any services provided at a rate in excess of the rates established by the state.

The Arkansas Medicaid Fraud Act makes it a criminal violation to purposely make or cause to be made any false statement or representation of a material fact to obtain benefits or payments under the Program for himself or another, or to convert the use of a benefit or payment from the intended recipient to another person. It is further a criminal violation to purposely solicit or receive remuneration, or offers or pays remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind in return for or to induce patient referrals or purchasing of goods and services for which payment is to be made in whole or in part under the Program.

What are the Penalties?

If a person commits a violation of the Arkansas Medicaid Fraud False Claims act, the person is liable to the State of Arkansas for full restitution and for a civil penalty of not less than \$5,000 and not more than \$10,000 for each violation, plus three (3) times the amount of all payments judicially found to have been fraudulently received from the Arkansas Medicaid program *unless the court finds the following*:

(A) The person committing the violation furnishes officials of the Attorney General's office with all information known to the person about the violation within thirty (30) days after the date on which the defendant first obtained the information; and

(B) The person fully cooperated with any Attorney General's investigation of the violation, and at the time the person furnished the Attorney General with the information about the violation:

(i) No criminal prosecution, civil action, or administrative action had commenced with respect to the violation; and

(ii) The person did not have actual knowledge of the existence of an investigation into the violation.

Further, the applicable agency director may suspend or revoke the provider agreement between the agency and the person in the event that a person is found guilty of violating the terms of the Medicaid Fraud False Claims Act.

If a person violates the Arkansas Medicaid Fraud Act, the person may be subject to criminal penalties and liable for full restitution to the state. A conviction of Medicaid fraud is a Class B felony if the aggregate amount of payments illegally claimed is \$2,500 or more, and a Class C felony if the amount of payments illegally claimed is between \$200 and \$2,499. Should a person or provider be found guilty or have plead to a criminal offense under this act, it is illegal for that person to participate directly or indirectly in the Arkansas Medicaid Program and it is illegal for a provider to hire or engage that person as an independent contractor. Illegal Medicaid participation is a Class A misdemeanor for the first offense, Class D felony for the second offense, and Class C felony for the third offense. Additionally, any person against whom any civil judgment is entered as the result of a civil action brought or threatened to be brought by the State of Arkansas on a complaint alleging the person to have fraudulently received any payment from the Arkansas Medicaid Program is required to pay a civil penalty of two (2) times the amount of all payments found to have been fraudulently submitted, and may be required to pay a civil penalty in any amount up to \$2,000 for each claim found to have been fraudulently submitted.

In addition, any person found guilty of fraud under the Arkansas Medicaid Fraud Act is required to make

full restitution to the Department of Health and Human Services, pay a mandatory fine in the amount of three (3) times the amount of all payments found to have been illegally received, and may be required to pay a fine in any amount up to \$3,000 for each claim found to have been fraudulently submitted. These criminal fines shall not be applied to the same claim or payment as the civil penalties described under the Arkansas Medicaid Fraud False Claims Act.

Who Can Make a Claim for a Violation?

The Arkansas False Claims Act contains a provision for an individual to bring a *qui tam* suit. It is very similar to the Federal False Claims Act, including allowing the Arkansas Attorney General the right to elect to bring suit on behalf of the reporting individual. However, if the Attorney General elects not to pursue the claim, the reporting person has a right to proceed with the suit and any and all expenses will be the responsibility of the reporting person. Should the claim proceed and a provider is found liable, the person making the claim is eligible for an award in the form of a percentage of the proceeds of the action not to exceed \$100,000.

Retaliation Prohibited

Arkansas has not enacted a provision for the protection of “whistle-blower” employees of private companies reporting Medicaid fraud or violations similar to the federal False Claims Act. *See the Federal False Claims Act.*

References: A.C.A. §§ 20-77-901, *et seq.*; A.C.A. §§ 5-55-101, *et seq.*

Rev'd 4/27/10

FLORIDA MEDICAID FRAUD LAWS

What is a Violation?

Under the Florida False Claims Act, a person commits an unlawful act if, for example, a person knowingly: (i) fails to disclose a material fact used to make a determination of eligibility to receive state or federal assistance funds; (ii) misappropriates funds given by a state or federal assistance program; (iii) files a claim for payment for services not rendered; (iv) in any way knowingly fails to credit the state or its agents for payments received from other sources; or (v) knowingly receives unauthorized payments or other unauthorized public assistance or identification to obtain public assistance.

Under the Florida Medicaid Provider Fraud Statute, a person commits a criminal offense if, for example, he/she knowingly makes, causes to be made, or aids and abets in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent or a managed care plan for payment, or a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

What are the Penalties?

If a person commits a violation of the Florida False Claims Act, the person is liable to the State of Florida for full restitution and for a civil penalty of not less than \$5,500 and not more than \$11,000 for each violation, plus no less than two (2) times and up to three (3) times the amount of damages sustained by the state because of the act or omission.

If a person commits a violation of the Florida Medicaid Provider Fraud Statute, he/she may be subject to the following criminal penalties: fraud of \$10,000 or less is a third-degree felony punishable by imprisonment of no more than five (5) years; fraud greater than \$10,000 and less than \$50,000 is a second-degree felony punishable by imprisonment of no more than fifteen (15) years; and fraud of \$50,000 or more is a first-degree felony punishable by imprisonment of no more than thirty (30) years. A person convicted of a violation shall also be required to pay the highest of the following fines: a) a fine equal to five (5) times the amount of the pecuniary gain unlawfully received, b) a fine equal to five (5) times the amount of the loss incurred by the Medicaid program; or c) a fine of \$5,000 for a third-degree felony, or a fine of \$10,000 for a second- or first-degree felony.

Who Can Make a Claim for a Violation?

The Florida False Claims Act also contains a provision for an individual to bring a *qui tam* suit. It is very similar to the Federal False Claims Act. The Florida Attorney General and/or the Florida Comptroller may elect to intervene and proceed with the action. The Attorney General or Comptroller may voluntarily dismiss the action despite objections of the person initiating the action. However, the person initiating the action has the election to continue with the action at his/her own expense. Further, the state or the defendant may ask the court to limit the participation of the person initiating the action if it is in the best interests of the state or if the person's continued participation is for purposes of harassment or would cause the defendant undue burden or unnecessary expense. The initiating person may be awarded a percentage of the proceeds recovered, which amount is determined by the court and based on the extent to which the person substantially contributed to the prosecution of the action.

Retaliation Prohibited

Florida also protects employees reporting Medicaid fraud from being discharged, demoted, suspended, threatened, or harassed or in any other manner discriminated against in the terms and conditions of employment by his or her employer. Specifically, Florida has in effect a "Whistle-blower's Act" that protects an employee who reports a violation of the law to an appropriate agency from adverse action by the employer.

References: Fla. Stat. §§ 68.081, *et seq.*; Fla. Stat. §§ 112.3187, 409.920, 414.39, 775.082, *et seq.*

INDIANA MEDICAID FRAUD LAWS

What is a Violation?

Under Indiana civil and criminal statutes, a person or organization commits Medicaid Fraud, for example, by billing for nonexistent patients or patients of other providers, billing for services not provided, billing for used medical equipment as though it were new, billing for unnecessary treatment or testing, billing for physicians' services that are actually provided by unlicensed personnel, accepting kickbacks from referrals, billing for lengthy counseling sessions when only short sessions were provided, or making a patient pay more than a Medicaid-approved co-payment for services.

What are the Penalties?

If there is a finding in favor of the state as a result of the civil action, the person or provider committing the act or acts shall be liable in a minimum amount of \$5,000 up to an amount not to exceed three (3) times the amount paid to the provider in excess of the amount that was legally due and/or a civil penalty of not more than \$500 for each instance of overpayment, and/or reimbursement to the attorney general for reasonable costs of the investigation and enforcement action.

Further, a criminal violation such as theft, receiving or providing bribes under these statutes is a Class A misdemeanor. A person who knowingly or intentionally files a false Medicaid claim, obtains payment from Medicaid by means of false or misleading oral or written statement, falsifies documents or records of a provider, or conceals information for the purpose of applying for or receiving unauthorized payments from the Medicaid program commits a Class D felony if the fair market value of the offense is less than \$100,000 and a Class C felony for offenses over \$100,000.

Who Can Make a Claim for a Violation?

An individual may bring a civil action for violation of the Indiana Code on behalf of the state, or a "*qui tam*" suit. The Attorney General or Inspector General may choose to intervene in the civil action. However, if the state does not choose to intervene or dismisses the suit on behalf of the state after intervention, the individual may continue to prosecute the civil action at his or her own expense. Should the civil action proceed and there is either a settlement or a finding against the provider, the individual original complainant may receive a percentage of the award and attorney's fees and expenses. The amount of the percentage is determined by the court taking into consideration the extent to which the finding is based on the information provided by the complainant and whether or not the state prosecuted the action versus the individual. If the state finds that the individual planned and initiated the violation or is convicted of a crime related to the violation, the individual is not entitled to an award. If the state did not intervene in the prosecution of a claim and the court finds that the claim is frivolous, the court may award the defendant/provider reasonable attorney's fees, expenses and costs of defending the action against the individual complainant.

Retaliation Prohibited

Indiana also has established whistleblower protections. Specifically, an employee who has been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by the employee's employer because the employee made a claim, reported a violation, or participated in a civil action for Medicaid fraud against the employer is entitled to relief in the form of reinstatement with no loss of status, two (2) times the amount of back pay owed the employee, interest on the back pay, and compensation for any special damages sustained as a result of the discriminatory act.

References: Burns Ind. Code. Ann. §§ 5-11-5-5, *et seq.*; Burns Ind. Code. Ann. §§ 12-15-12-1, *et seq.*; Burns Ind. Code. Ann. § 22-5-3-3, Burns Ind. Code. Ann. § 35-43-5-7.1

MISSISSIPPI MEDICAID FRAUD LAWS

What is a Violation?

The State of Mississippi passed the Mississippi Medicaid Law (1964) and Medicaid Fraud Control Act (1984), which contain provisions similar to the federal False Claims Act. It is a violation of the law for any person making application for Medicaid benefits for himself/herself or another person and any provider to knowingly make a false statement or false representation or fail to disclose a material fact to obtain or increase any Medicaid benefit or payment. It is further a violation of the Act, for example, to solicit, offer or receive kickbacks or bribes in the furnishing of goods or services paid for, in whole or in part, by funds under the Medicaid program, or to make false, fictitious or fraudulent claims for payment by the Medicaid program.

What are the Penalties?

Violators of the Mississippi Medicaid Law are guilty of a misdemeanor for each act and fined in an amount not to exceed \$500 or imprisonment up to one (1) year, or both. A person who violates the Medicaid Fraud Control Act is guilty of a felony and shall be punished by imprisonment not to exceed five (5) years and/or fined in an amount not to exceed \$50,000.

In addition, civil penalties may be imposed equal to the full amount fraudulently received by the provider, plus an additional penalty of three (3) times the amount received by the provider.

Who Can Make a Claim for a Violation?

Neither the Mississippi Medicaid Law nor Medicaid Fraud Control Act contains separate *qui tam* provisions allowing individuals to bring suit on behalf of the state similar to the federal False Claims Act provisions.

Retaliation Prohibited

Mississippi has not enacted a "whistle blower" provision for protection of employees reporting Medicaid fraud or violations similar to the federal False Claims Act provisions.

References: Miss. Code Ann. §§ 43-13-129, 43-13-201, *et seq.*

Rev'd 5/26/08

MISSOURI MEDICAID FRAUD LAWS

What is a Violation?

The State of Missouri passed the Missouri Health Improvement Act of 2007, which includes statutes for protecting against, reporting and prosecuting Medicaid fraud. Violations include, for example, knowingly: (i) presenting a claim for payment that falsely states the health care provided was medically necessary; (ii) concealing an event affecting initial or continued payments by a medical assistance program for providing care; (iii) concealing or failing to disclose any information in order to obtain payment to which the health care provider is not entitled or improperly increasing the amount of any such payment; or (iv) making a claim for payment for health care which have a lesser value than that claimed. It is also a violation to solicit or receive any kickback, bribe, or rebate in return for referrals or for purchases or leases in relation to health care or to offer or pay any kickback, bribe or rebate to induce any person to refer another person to health care provider. In addition to other civil statutes, it is a violation to knowingly abuse a person receiving health care under the Medicaid program.

What are the Penalties?

A violation of these statutes is a Class C felony for the first conviction, which includes imprisonment of up to four (4) years, and a Class B felony for subsequent convictions, which includes imprisonment of up to fifteen (15) years. It is also a Class C felony to abuse a person receiving health care under the Medicaid program, unless the act involves no physical, sexual or emotional harm or injury and the value of the property involved is less than \$500, in which event it is a Class A misdemeanor. Any person who willfully prevents or obstructs or attempts to prevent or obstruct communication of information relating to a violation is guilty of a Class D felony. Any person who voluntarily reports a violation by himself/herself or their organization before such information is known to the Attorney General shall not be prosecuted for a criminal violation. Civil penalties may be imposed in the form of restitution in an amount equal to the full amount fraudulently received by the provider and reimbursement of the reasonable costs attributed to the investigation and prosecution. A violator may also be assessed a civil penalty in the minimum amount of \$5,000 to a maximum amount of \$10,000 for each separate violation, plus 3 times the amount of damages. In the event the violator furnished to the Attorney General information regarding the violation within thirty days after the violator first obtained the information, cooperated fully with the investigation, and furnished all information requested by the Attorney General, a court may reduce the amount to 2 times the amount of damages.

Who can Make a Claim for a Violation?

A private person may not file a *qui tam* lawsuit to allege a false claim; however, a person may report a violation to the Attorney General who may bring an action. A person who is the original source of the information used by the Attorney General to bring an action shall receive 10% of any recovery by the Attorney General.

Retaliation Prohibited

Similar to the federal False Claims Act, Missouri has enacted statutes protecting employees who make reports of violations under state law. Under the Missouri Health Improvement Act of 2007, employers may not discharge, demote, suspend, threaten, harass, or otherwise discriminate against an employee in the terms and conditions of employment because the employee initiates, assists or participates in a proceeding. An employer who violates this provision is liable to the employee for reinstatement of the employee, two (2) times the amount of lost back pay, and interest on the back pay. There are exceptions where the court finds the employee brought a frivolous or clearly vexatious claim, the employee planned, initiated, or participated in the alleged fraud, or is convicted of criminal conduct arising from the alleged violation.

References: Mo. Rev. Stat. §§ 191.900-.910

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NEW MEXICO MEDICAID FRAUD LAWS

What is a Violation?

The New Mexico Medicaid False Claims Act deters persons from causing or assisting to cause the state to pay Medicaid claims that are false and to provide remedies and penalties for such acts. Violations of the Act include: (i) presenting a false or fraudulent claim for payment under the Medicaid program; (ii) making a claim for payment under the Medicaid program benefiting a person who is not authorized or is ineligible for the benefit; (iii) falsifying or presenting a false record in order to make a fraudulent claim paid for or approved by the state knowing such record is false; (iv) conspiring to defraud the state for a payment under the Medicaid program; (v) making or using a record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state, relative to the Medicaid program, knowing that such record is false; (iv) making a false statement of material fact in order that a facility may qualify for certification or recertification required by Medicaid; or (v) making a claim under the Medicaid program for a service or product that was not provided.

What are the Penalties?

If a person commits a violation of the New Mexico Medicaid False Claims Act, the person is liable for civil money penalties to the State of New Mexico in the amount of three (3) times the amount of damages sustained by the state because of the act or omission. Additional civil penalties include payment of interest, legal fees and costs of investigation and enforcement, and up to \$10,000 for each false or fraudulent claim. There are also criminal penalties in accordance with the New Mexico Medicaid Fraud Act. Individuals who commit Medicaid fraud may be punishable ranging from petty misdemeanor to second degree felony, depending on the value of the benefit, treatment, services or goods improperly provided. Also, a person who commits Medicaid fraud resulting in physical or psychological harm to a recipient commits an offense ranging from a fourth degree felony to, in the event of death of a recipient, a second degree felony. If an entity rather than an individual commits Medicaid fraud, the entity is subject to a fine of not more than \$50,000 for each misdemeanor and not more than \$250,000 for each felony.

A provider may also be subject to an administrative penalty of not more than \$5,000 for engaging in any practice in violation of the Medicaid Provider Act or Public Assistance Act. In addition, the Medicaid Provider Act and Public Assistance Act make it a violation to (i) intentionally or with reckless disregard make any false statement with respect to any report or statement required by the Acts or (ii) fraudulently procure or attempt to fraudulently procure any benefit from Medicaid.

Who Can Make a Claim for a Violation?

The New Mexico Medicaid False Claims Act also contains a provision for an individual to bring a *qui tam* suit. The New Mexico Attorney General may elect to intervene and proceed with the action. The Attorney General may also voluntarily dismiss the action after notice to the person initiating the action and despite the individual's objections, following which the person initiating the action has the election to continue with the action at his/her own expense. The state may also settle the suit despite the objections of the individual complainant upon notice to the individual complainant, and hearing and order of the court. If the action is concluded by trial or settlement, the initiating individual may receive an award of a percentage of the amount of the proceeds. The amount of the award depends on the extent to which the person substantially contributed to the prosecution of the action. In the event the initiating person planned and initiated the violation upon which the action was brought, then the court may reduce the individual's share of the proceeds. In the event the initiating individual is convicted of criminal conduct arising from the violation, that person will be dismissed from the action and shall not receive any award. In the event a court finds that an action was filed for an improper purpose; is not warranted by existing law or by a non-frivolous argument for the extension, modification or reversal of existing law or the establishment of new law; or is based on allegations or factual contentions which are not supported, the court may award reasonable attorney's fees and costs to the defendant.

Retaliation Prohibited

As with the "whistleblower" protections under the federal False Claims Act, New Mexico has established an employee protection statute. Any employee who is discharged, demoted, suspended, threatened, harassed or otherwise discriminated against in the terms and conditions of employment by their employer because the employee disclosed information to the state regarding a violation of the False Claims Act or cooperated in the investigation or proceeding with an action as a result of a violation of the False Claims

Act may seek recovery of damages. The employee may be entitled to reinstatement without loss of seniority, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages, including litigation costs and reasonable attorney's fees.

References: N.M. Stat. Ann. §§ 27-2-1, 27-11-1, 27-11-3, 27-14-1, *et seq.*; N.M. Stat. Ann. §§ 30-44-1, *et seq.*

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PENNSYLVANIA MEDICAID FRAUD LAWS

What is a Violation?

Pennsylvania does not have a false claims act similar to the federal False Claims Act. Pennsylvania has established statutes to deter and penalize acts of Medicaid or other medical assistance fraud. Acts prohibited under Pennsylvania law include, for example: (i) presenting for payment any false or fraudulent claim for services or merchandise; (ii) presenting for payment a claim for medically unnecessary services or merchandise; (iii) submitting false information for the purpose of obtaining greater compensation than that to which a provider is legally entitled; (iv) submitting false information for the purpose of obtaining authorization for furnishing services or merchandise; solicit or receive or to offer or pay any remuneration, including any kickback, bribe or rebate in connection with referrals for services for which payment may be made in whole or in part under the medical assistance program; (v) submitting a duplicate claim for services; (vi) submitting a claim for services which were not rendered to a recipient; or (vii) submitting a false statement or representation on behalf of another individual.

What are the Penalties?

A violation of the Pennsylvania fraud and abuse statutes, with the exception of failure to confirm eligibility through a current identification card, is a third degree felony for each such violation with a maximum penalty of \$15,000 and 7 years imprisonment. Subsequent violations are classified as second degree felonies with a maximum penalty of \$25,000 and 10 years imprisonment. In addition to criminal penalties, a trial court may also order a violator convicted under these statutes to (i) repay the amount of the excess benefits or payments received plus interest at the maximum legal rate; and/or (ii) pay an amount not to exceed 3 times the amount of excess benefits. A person convicted under these statutes will be prohibited from participating in the medical assistance program for a period of 5 years from date of conviction. If a provider has committed a violation, the Department of Public Welfare may terminate, upon notice to the provider, the provider agreement and may institute a civil suit against the provider. The penalty for submitting a false statement on another person's behalf is dependent upon the amount of the benefit received as a result of the false statement, and can range from a third-degree misdemeanor to a third-degree felony.

Who Can Make a Claim for a Violation?

Pennsylvania has not enacted a separate *qui tam* provision allowing an individual to bring suit on behalf of the state similar to the provisions of the federal False Claims Act.

Retaliation Prohibited

Pennsylvania has established a "whistle-blower" law. Pursuant to Pennsylvania law, no employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste, or participates in an investigation or prosecution at the request of an appropriate authority. A person who, under color of an employer's authority, violates the whistleblower act shall be liable for a civil fine of not more than \$500. A court may also order reinstatement of the employee with fringe benefits and seniority rights, payment of back wages, actual damages, or any combination of these remedies, in addition to litigation costs. It is a requirement for the employer to post notices and use other appropriate means to notify employees of the protections and obligations under the whistleblower act.

References: 43 P.S. §§ 1422-1426, 1428; 62 P.S. §§ 1401, 1407, 1408

TEXAS MEDICAID FRAUD LAWS

What is a Violation?

Texas' version of the False Claims Act is substantially similar to the federal False Claims Act with a few additions. A person commits an unlawful act under the Texas Medicaid Fraud Prevention Act if, for example, a person knowingly: (i) makes a false statement for payment under the Medicaid program; (ii) conceals information resulting in receipt of a benefit or payment which is not authorized under Medicaid; (iii) converts any part of payment to a use other than for the benefit of the person entitled to the payment; (iv) solicits a gift or money as a condition to provide services already paid for under Medicaid; (v) makes a claim for payment for a service rendered by a person not licensed to provide those services; (vi) makes a claim for a service that has not been ordered or approved by a treating physician or health care practitioner; (vii) fails to indicate the type of license and identification number of the licensed health care provider on a claim presented for payment.

Violations of the Administrative Provisions of Hum. Res. Code. Ann. § 32.039 – Medical Assistance Programs, include: (i) presenting or causing to be presented a claim that the person knows or should know is false; (ii) soliciting or receiving, or offering or paying, kickbacks, bribes, or rebates, in cash or in kind, for patient referrals; (iii) soliciting or receiving, or offering or paying, kickbacks, bribes, or rebates, in cash or in kind, in return for purchasing, ordering, or recommending the purchase or order of any goods or services for which payment is made under the medical assistance program; (iv) providing, offering, or receiving an inducement for the purpose of influencing decisions regarding selection of a provider or receipt of a good or service, the use of goods or services, or the inclusion or exclusion of goods or services paid for, in whole or in part, by the medical assistance program.

What are the Penalties?

If a person commits a violation of the Medicaid Fraud Prevention Act, the person is liable to the state for the amount paid, if any, as a result of the violation and interest on that amount and a civil penalty in an amount not to exceed twice the amount paid, if any, as a result of the violation plus a minimum of \$5,000 or maximum of \$15,000 for each violation that results in injury to an elderly person, a disabled person, or a person younger than 18 years; or not more than \$10,000 for each violation that does not result in such an injury.

Also, a health and human service agency may suspend a provider agreement between the agency and a person who commits unlawful acts under the Medicaid Fraud Prevention Act. In addition, a provider found liable for an unlawful act may not, for a period of 10 years, provide or arrange to provide healthcare services under the Medicaid program or supply or sell, directly or indirectly, a product to or under the Medicaid program. This time may be extended or an exemption made at the discretion of the Health and Human Services Commission.

Similarly, violations may be punishable under Chapter 32 of the Human Resources Code in the amount paid on a false claim, plus interest, and an administrative penalty in an amount not to exceed twice the amount paid, plus an amount (a) not less than \$5,000 or more than \$15,000 for each violation that results in injury to an elderly person, a disabled person, or a person younger than 18 years, or (b) not more than \$10,000 for each violation that does not result in such an injury.

Who Can Make a Claim for a Violation?

The Medicaid Fraud Prevention Act also contains a provision for an individual to bring a *qui tam* suit. It is very similar to the Federal False Claims Act, including provisions requiring the Texas Attorney General to either intervene and prosecute the suit or decline. If the Texas Attorney General declines to take over the suit, the individual bringing the claim may continue with the suit. Should the claim proceed and a provider is found liable, the original individual making the claim is eligible for an award in the form of a percentage of the proceeds of the action, depending on the extent to which the person substantially contributed to the prosecution of the action. However, if a court finds that the action is brought by a person who planned and initiated the violation on which the action is brought or if the individual is convicted of criminal conduct arising from the act initiating the claim, the court may reduce the share of the proceeds awarded to the individual making the claim or exclude the individual from receiving any proceeds. Also, if the information

provided by an individual results in a recovery of administrative penalties under Chapter 32 of the Human Resources Code, the individual may receive an award not to exceed five percent (5%) of the administrative penalty imposed under the Texas Government Code § 531.101, *et seq.*

Retaliation Prohibited

As with the Federal False Claims Act, Texas prohibits retaliation by an employer against an employee who engages in a lawful act in furtherance of an action against a provider, including investigation, initiation, testimony, or assistance in an action filed or to be filed against a provider. Employees are protected from being fired, demoted, threatened or harassed by their employer in retaliation for cooperating in the pursuit and litigation of a claim. If a court finds that the employer retaliated against the employee, the court can order the employer to reinstate the employee, pay the employee back pay, and any other compensation arising from retaliatory conduct.

References:

Tex. Gov. Code Ann. §§ 531.101, *et seq.*; Tex. Hum Res. Code Ann. §§ 32.039, 36.001, *et seq.*

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